DEPARTMENT OF HEALTH AND HUN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 07/14/2010 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		295037	B. WI			С
		293037				07/08/2010
NAME OF PROVIDER OR SUPPLIER				ļ.	REET ADDRESS, CITY, STATE, ZIP CODE	
HENDER	RSON HEALTHCARE	CENTER			180 E. LAKE MEAD DRIVE	(
	,			F	ENDERSON, NV 89015	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOIL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE / MPLETION
	1				DEFICIENCY)	04/20/10
F 284 SS=D	This Statement of Da result of the compat your facility on Ju July8, 2010, in account Part 483 Require Facilities.  Complaint #NV0028  The findings and co by the Health Division prohibiting any crimactions or other clain available to any particular state, or local laws.  The following deficient 483.20(I)(3) ANTICI POST-DISCHARGE When the facility and must have a discharge plan the participation of the state of the control of the company	Deficiencies was generated as plaint investigation conducted ally 8, 2010, and finalized on ordance with 42 CFR Chapter ments for Long Term Care and as substantiated.  The standard or civil investigation on shall not be construed as inal or civil investigation, ms for relief that may be try under applicable federal, ancies were identified:  PATE DISCHARGE:  PLAN  Tricipates discharge a resident rege summary that includes a of care that is developed with the resident and his or her sist the resident to adjust to		284	and executed because it is required by the provisions of the state federal regulations and not be Henderson Healthcare Center with the allegations and citatilisted on the statement of deficiencies. Henderson Healthcare Center maintains that the allegaticiencies do not, collective jeopardize the health and safe the residents, nor are they of scharacter as to limit our capacite render adequate care as prescriby regulation. This plan of correction shall operate as Henderson Healthcare Center written credible allegation of compliance.  By submitting this plan of con Henderson Healthcare Center not admit to the accuracy of the state of the	and cause agrees ons  Ithcare ged ely, ty of such city to ribed  rection, does he
	This REQUIREMEN by: Based on interview a failed to ensure a podeveloped with the firesident/family for 1 (Resident #1). Findings include:	T is not met as evidenced and record review, the facility at discharge plan of care was	IATURF		deficiencies. This plan of cor is not meant to establish any sof care, contract, obligation, o position, and Henderson Heal Center reserves all rights to rapossible contentions and defer any civil or criminal claim, ac proceeding.	standard or thcare ise all nses in tion or
,	S. C.	A ) - I	MIUKE			(X6) DATE
	1///10	MINTH	_		ANUNISTRAPON	1/12/2010

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YDLM11

Facility ID: NVS263S

If continuation sheet Page 1 of 2

## DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 07/14/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		295037	B. Wi	NG		1	C <b>8/2010</b>
NAME OF PROVIDER OR SUPPLIER HENDERSON HEALTHCARE CENTER				STR 1			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIEM (PROSS-REFERENCE)	OULD BE	(X5) COMPLETION DATE
	diagnoses including debility. Documenta indicated the reside central catheter (PIC Review of Resident administration recor intravenous access medications for ten discharge on 5/17/1 Documentation in R a discharge plan the discharged to a growservices. There was Case Management Assessment of a PIC no documentation of form signed by the pfacility to the home had the facility discharge a group home with a physician's orders of necessity.  On 7/8/10 at 2:45 PIC employee was unawline in place when the	Imitted on 5/6/10, with syncope, fractured wrist, and ation in Resident #1's record in thad a peripherally inserted CC) line in the right upper arm. #1's medication d for May 2010, indicated the had not been used to provide days prior to the resident's 0.  esident #1's record indicated at the resident would be up home with home health is no documentation on the Admission and Discharge CC line in place. There was fa PICC line on the referral physician and faxed by the	F	284	a. Resident #1 is no longer resident of the facility.  b. A 100% audit has been c to identify all residents with lines to ensure proper dischaplanning is in place.  c. The professional nursing been re-educated on proper planning specifically the ren PICC lines as appropriate. In nursing staff has also been reducated regarding required documentation on all admiss discharges.  d. Random audits will be contonensure compliance. The result the facility PI meetings.  e. The individual responsible compliance is the Director on Nursing.  f. Compliance date is July 2.	onducted PICC arge  staff has discharge noval of The e- sions and onducted results of d trended le for f	

ORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YDLM11

Facility ID: NVS263S

If continuation sheet Page 2 of 2



## DEPÄRTMENT OF HEALTH AND HUM CENTERS FOR MEDICARE & MEDICARE

 10000

PRINTED: 07/14/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(NZ) MOZIN ZZ SSI		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING		С		
295037			B. WING		07/08/2010	
NAME OF PROVIDER OR SUPPLIER HENDERSON HEALTHCARE CENTER			11	EET ADDRESS, CITY, STATE, ZIP CODE 80 E. LAKE MEAD DRIVE ENDERSON, NV 89015	TION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE C	(X5) COMPLETION DATE
F 284 SS=D	a result of the compat your facility on July8, 2010, in acc IV Part 483 Require Facilities.  Complaint #NV002  The findings and coby the Health Division prohibiting any crimactions or other clausailable to any pastate, or local laws.  The following deficition 483.20(I)(3) ANTIC POST-DISCHARG  When the facility armust have a discharge plant the participation of family, which will ashis or her new livin  This REQUIREME by: Based on interview failed to ensure a product of the participation of family, which will ashis or her new livin  This REQUIREME by: Based on interview failed to ensure a product of the participation of family, which will ashis or her new livin  This REQUIREME by: Based on interview failed to ensure a product of the participation of family for (Resident #1).  Findings include:	Deficiencies was generated as plaint investigation conducted ally 8, 2010, and finalized on ordance with 42 CFR Chapter ements for Long Term Care 5397 was substantiated.  Inclusions of any investigation ion shall not be construed as plainal or civil investigation, ims for relief that may be rety under applicable federal, includes a plain of care that is developed with the resident and his or her issist the resident to adjust to genvironment.  In order of care was evidenced and record review, the facility post discharge plan of care was		This plan of correction is prepand executed because it is received by the provisions of the state federal regulations and not be Henderson Healthcare Center with the allegations and citatilisted on the statement of deficiencies. Henderson Healthcare Center maintains that the alledeficiencies do not, collective jeopardize the health and safe the residents, nor are they of character as to limit our caparender adequate care as pressed by regulation. This plan of correction shall operate as Henderson Healthcare Center written credible allegation of compliance.  By submitting this plan of content admit to the accuracy of deficiencies. This plan of content admit to the accuracy of deficiencies. This plan of content is not meant to establish any of care, contract, obligation, position, and Henderson Healthcare Center reserves all rights to possible contentions and definity and contentions and definity in the proceeding.	quired and ecause ragrees ions  althcare eged ely, ety of such acity to cribed  er as a constant or althcare raise all fenses in action or	(X5) DATE
ABORATOR	Y DIRECTOR'S OR FROM	DERISOPPLIER REPRESENTATIVES SIG	/	All wisty Long		

Sency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other Lafeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: NVS263S

## DEPÁRTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAR SERVICES

PRINTED: 07/14/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

(X3) DATE SURVEY COMPLETED

295037

B. WING \_\_\_\_\_

C 07/08/2010

NAME OF PROVIDER OR SUPPLIER

## HENDERSON HEALTHCARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 1180 E. LAKE MEAD DRIVE HENDERSON NV 89015

HENDERSON HEALTHCARE CENTER			HENDERSON, NV 89015			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE	
F 284		F 2	284	a. Resident #1 is no longer a resident of the facility.  b. A 100% audit has been conducted to identify all residents with PICC lines to ensure proper discharge planning is in place.  c. The professional nursing staff has been re-educated on proper discharge planning specifically the removal of PICC lines as appropriate. The nursing staff has also been re-educated regarding required documentation on all admissions and discharges.  d. Random audits will be conducted to ensure compliance. The results of the audits will be tracked and trended at the facility PI meetings.  e. The individual responsible for compliance is the Director of Nursing.  f. Compliance date is July 23, 2010.		
	·			of the ID-NIVS263S If continuation sh	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YDLM11

Facility ID: NVS263S

If continuation sheet Page 2 of 2

